Surgeons claim independent centres produce poor results

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The NHS is acting as a safety net for patients who receive inferior treatment at independent sector treatment centres that have yet to prove themselves, MPs have been told. Worries about the quality of independent sector treatment centres (ISTCs) were voiced by various doctors' representatives to the health parliamentary select committee last week at the first session of oral evidence in the committee's inquiry into these centres.

England has 20 independent sector treatment centres, with 10 more planned. The first centre opened in October 2003 under a partnership agreement between the NHS and the private sector to carry out specific procedures to help with the NHS's lack of capacity and waiting lists.

Ian Leslie, the president of

the British Orthopaedic Association, told the committee, "I have not, from any of our members, found one group who have said that things have improved as a result of a localised ISTC."

Mr Leslie admitted that evidence of bad practice was merely anecdotal, but he added, "There is now enough evidence gathering out there. My colleagues see the bad results coming back. Bad results perhaps in eye surgery and hernia surgery occur rapidly."

"In orthopaedic surgery, they occur over five years, maybe 10 years, so we are seeing dislocation rates and revision rates, and if one is seeing that with our patients, it is no wonder we are being negative about the way it is being done."

In evidence that closely mirrored the words of another

orthopaedic surgeon, Professor Angus Wallace, in the *BMJ* last week (2006;332:614, 11 March), Mr Leslie said: "You can say these ISTCs have been successful in waiting lists, but at a price – both a monetary one, and also there are a lot of patients out there who are having problems as a result of that innovation."

The president of the Royal College of Surgeons of England, Bernard Ribeiro, told the committee, "The fact is there is a lack of will to follow through by having these centres in the NHS because it's government policy to contest, challenge the NHS, put independent sector treatment centres nearby, and see whether the NHS hospital nearby will deliver, and if it can't deliver, then it goes down."

The BMA, in written evidence submitted to the inquiry,

said that it was concerned that, because of the "current lack of robust audit data on outcomes" the public and the NHS were unable to assess properly the quality of services or whether they were value for money.

Civil servants, also giving evidence, said that there had been no destabilisation of existing NHS services as a result of the treatment centres but said that training was an issue. Bob Ricketts, head of demand side reform for the Department of Health, said, "If you are moving out many of the frequent but simpler procedures that junior medical staff train on, then that is an area we need to make sure we don't inadvertently destabilise. That is why we have been in discussion with the Royal Colleges around how do we actually manage training."

The inquiry continues.

Code sets out framework for "living wills"

Clare Dyer *legal correspondent, BMJ*

A code of practice under the new Mental Capacity Act for doctors and others who deal with people who cannot take decisions for themselves was issued in draft for consultation last week. The draft code, which applies to England and Wales, sets out how capacity should be assessed, how advance directives on treatment will operate, and how decisions about treatment should be taken once the act is in operation.

The act, which is expected to come into force in April 2007, sets out a statutory framework for advance directives or "living wills." These set out a patient's wishes about future treatment and come into operation if the patient becomes incapacitated. Living

wills are already binding on doctors under common law if their terms are sufficiently certain.

For the first time, the act will allow a person who is of sound mind to appoint a friend or relative to consent to or to refuse treatment, should they later become incapacitated. And a new court of protection will be able to take decisions on behalf of those lacking capacity or appoint a deputy, such as a relative or social worker, to decide on their behalf.

The act has provoked controversy, with one tabloid newspaper claiming that it promotes euthanasia and will mean that doctors would face prosecution if they refused to allow patients to die in accordance with their

"living wills" (*Daily Mail*, 10 March, p 1). In a bid to dispel such fears, the code points out that relieving suffering by causing death must not be a motivation for treatment decisions.

The code says that the thought, "He is suffering so much, it would be better for him to be dead," might well cross the

mind of a carer. "The law cannot stop the carer from thinking such thoughts – whether out of compassion or from more sinister motives," it says.

But those taking treatment decisions on behalf of mentally incapacitated people cannot include the desirability of death in the assessment of what would be in the patient's best interests.

However, doctors cannot be obliged to provide life sustaining treatment, such as artificial nutrition and hydration, asked for in a living will, if they believe it to be against the patients' interests.

"Wherever possible, all steps should be taken to prolong life," says the draft code. But in exceptional cases or where the patient is close to death, intervention could cause "great suffering," it adds.

The draft code of practice is open for consultation until 2 June and is at www.dca.gov.uk/consult/codeofpractice/codeofpractice.htm.